2011 Procedures Adult Criteria

Spinal Cord Stimulator (SCS) Permanent Insertion, Revision, Configuration or Replacemement (Custom) - UDOH[1, 2]

Created based on InterQual Subset: Spinal Cord Stimulator (SCS) Insertion
Version: InterQual® 2011

CLIENT:	Name	D.O.B.	ID#	GROUP#
CPT/ICD9:	Code	Facility	Service Date	
PROVIDER:	Name		ID#	Phone#
	Signature		Date	

ICD-9-CM: 03.93, 86.94, 86.95, 86.96, 86.97, 86.98

INDICATIONS (choose one and see below)

- ☐ 100 Failed back surgery syndrome
- ☐ 200 Complex regional pain syndrome (CRPS)
- ☐ 300 Refractory angina
- ☐ 400 Surgical replacement, revision, or removal of previously implanted device
- ☐ 500 Replacement of electrodes
- ☐ Indication Not Listed (Provide clinical justification below)

☐ 100 Failed back surgery syndrome **[One]**[3, 4]
- ☐ 110 Successful completion of Utah Medicaid approved percutaneous trial period **[Both]**
  - ☐ 111 Trial period ≥ 3 days[5]
  - ☐ 112 Documented pain reduction ≥ 50% **[One]**[6]
    - ☐ -1 Numeric rating scale
    - ☐ -2 Visual analog scale

☐ 200 Complex regional pain syndrome (CRPS) **[One]**[7, 8]
- ☐ 210 Successful completion of Utah Medicaid approved percutaneous trial period **[Both]**
  - ☐ 211 Trial period ≥ 3 days[5]
  - ☐ 212 Documented pain reduction ≥ 50% **[One]**[6]
    - ☐ -1 Numeric rating scale
    - ☐ -2 Visual analog scale

☐ 300 Refractory angina **[One]**[9, 10, 11]
- ☐ 310 Successful completion of Utah Medicaid approved percutaneous trial period **[Both]**
  - ☐ 311 Trial period ≥ 3 days[5]

InterQual® criteria are intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determination concerning the type or level of medical care provided, or proposed to be provided, to the patient.

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☐ 312 Pain reduction ≥ 50% **[One]**[6]
- ☐ -1 Numeric rating scale
- ☐ -2 Visual analog scale

☐ 400 Surgical replacement, revision, or removal of previously implanted device

☐ 500 Replacement of electrodes

Notes

(1)
These criteria include the following procedure:
Dorsal Column Stimulator Insertion

(2)
A spinal cord stimulator (SCS) is a battery operated device consisting of electrodes that are permanently implanted in the epidural space around the spinal cord and a neurostimulator that is usually placed in an abdominal pocket under the skin. The main unit and the electrodes are connected by a cable that is tunneled under the skin. The relative position of the electrodes, their orientation, distance from the spinal cord, and the electrical output all influence the effectiveness of the therapy which provides paresthesia to the painful area (Rushton, Disabil Rehabil 2002; 24(8): 407-415). SCS is appropriate only after failure of other pain management modalities and should not be a first-line intervention. Life threatening or major complications are uncommon but surgery may be needed for migration or incorrect placement of electrodes, battery replacement, or infection.

(3)
Recurrent pain after surgery (the "failed back") is difficult to evaluate and treat. It can occur in up to 40% of patients following back surgery. The cause of pain may not be surgically remediable (Jinkins and Van Goethem, Radiol Clin North Am 2001; 39(1): 1-29).

(4)
One prospective study compared patients with failed back syndrome who received SCS treatment with a control group maintained on medical therapy alone. The SCS group reported a 27% improvement in quality of life measures, an overall reduction in medication usage, and a 15% increase in employment (Kumar et al., Neurosurgery 2002; 51(1): 106-115; discussion 115-116).

(5)
The economics of healthcare today demand patients eligible for high technology equipment be screened to assure that those with the best chance for success are the ones receiving it. Therefore, a percutaneous trial of SCS is frequently used to determine if neurostimulation will be effective in treating refractory pain (Rushton, Disabil Rehabil 2002; 24(8): 407-415). Patients who have positive results during the trial are candidates for a permanent unit. Pain control, however, is not guaranteed even after a successful trial period (Kay et al., Br J Neurosurg 2001; 15(4): 335-341).

(6)
Many tools exist to measure the subjective experience of pain, such as the visual analog scale (VAS), the numerical rating scale (NRS), the Faces scale, or the McGill pain questionnaire (Doleys et al., Anesthesiol Clin North America 2003; 21(4): 767-783). The two most commonly used scales are the NRS and VAS. The method used to document the level of pain depends on the patient's cognitive, verbal, auditory, motor, and educational capacities. The NRS is currently used in clinical practice across a wide spectrum of age groups and allows one to verbally report the pain level on a scale of 0 to 10. The VAS consists of a 10 cm line with the left end labeled no pain and the right end labeled severe pain; the patient marks their pain level along the continuum. The VAS method requires the use of a writing instrument as well as abstract thinking, so it may not be appropriate for patients with cognitive or motor impairment (Herr et al., Clin Geriatr Med 2001; 17(3): 457-478, vi).

(7)-DEF:
Complex regional pain syndrome is a reclassification of reflex sympathetic dystrophy and causalgia. Complex regional pain syndrome has been subdivided into two types, Type I and Type II (Albazaz et al., Ann Vasc Surg 2008; 22(2): 297-306).
• Complex Regional Pain Syndrome I: Symptoms (burning pain, hyperalgesia, temperature change, skin color changes, trophic

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changes, localized swelling, motor dysfunction, sensory paresthesias) usually after trauma, without an overt nerve injury. Motor symptoms can include stiffness, dystonic movements, posturing, myoclonic jerks, tremor, and weakness. Pain is not confined to a single peripheral nerve distribution.

• Complex Regional Pain Syndrome II or causalgia: A regional pain syndrome, characterized by intense, continuous, burning pain and hyperalgesia that usually develops after nerve injury. The pain may spread outside the nerve distribution over time.

(8)

One study evaluated SCS for patients with CRPS. The SCS treatment group reported an 11% improvement in their quality of life primarily due to a decrease in pain. Many of the subjects were disabled at the beginning of the study due to muscle atrophy and joint contractures. Treatment with SCS did not have an impact on these problems (Kemler et al., N Engl J Med 2000; 343(9): 618-624).

(9)-DEF:

Angina pectoris is defined as discomfort in the chest associated with myocardial ischemia. Symptoms of angina may vary from patient to patient and include sensations of pain (classically involving the chest with radiation to the left arm), choking, pressure, squeezing, tightness, heaviness, or burning. Isolated shoulder, back, neck, and jaw complaints can also be described.

(10)

Patients with refractory angina have ischemia confirmed by testing (e.g., ETT, stress echo) and symptoms so severe they experience discomfort with ordinary physical activity or have limited physical activity. These patients can be unresponsive to all conventional medical therapies, as well as revascularization surgery (Kim et al., J Am Coll Cardiol 2002; 39(6): 923-934).

(11)

Both retrospective and observational studies have shown a decrease in anginal pain with the use of SCS. The mechanism of action is not fully understood but it is hypothesized that in addition to pain blockade, there is an anti-ischemic component to the therapy. In a prospective study, patients with refractory angina who were not candidates for surgical intervention were treated with SCS. The study showed a significant improvement of anginal symptoms (Lapenna et al., Ann Thorac Surg 2006; 82(5): 1704-1708). The concern that treatment with SCS will result in increased cardiac death secondary to the masking of the clinical symptoms of MI is not supported by the data (Di Pede et al., Am J Cardiol 2003; 91(8): 951-955).

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